Retiree Health Insurance

Background

Health insurance has become one of the most significant expenses retirees face, particularly those who leave employment before Medicare eligibility. Because the cost of health insurance continues to rise faster than the average change in consumer prices, it absorbs an ever-greater share of retirees' income, and can diminish the adequacy of their remaining retirement benefits.

This paper covers the current provisions related to retiree health insurance as it relates to members of State-administered retirement systems and plans. It also discusses the nationwide trends in health care costs and how those costs have a greater impact on the elderly population. And to conclude, it discusses the measures of health care inflation and which of those measures most closely reflects the experience of retirees.

Committee Activity

Presentation:
September 7, 2004 - Full Committee

Recommendation to Legislature

None.

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Select Committee on Pension Policy

Retiree Health Insurance

(August 31, 2004)

Issue

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Members Impacted

Members of all systems and plans except the Law Enforcement Officer's and Fire Fighters retirement system plan 1 whose members receive full health care coverage in retirement.

Current Situation

Currently, retired or disabled state employees, retired or disabled school employees, retired or disabled higher-education employees, or employees of county, municipal, or other political subdivisions who are retired may continue their participation in employer provided insurance plans and contracts after retirement or disablement. Separated employees may continue their participation if it is selected immediately upon separation from employment.

Surviving spouses and dependent children of emergency service personnel killed in the line of duty may also participate in insurance plans and contracts.

Premiums charged to retired or disabled employees, separated employees, spouses, surviving spouses of emergency service personnel killed in the line of duty, or dependent children who are not yet eligible for Medicare parts A and B are based on the experience of the community rated risk pool. The risk pool is comprised of employees of school districts and educational service districts, state employees, retired or disabled school employees not yet eligible for Medicare parts A and B, and state retirees not yet eligible for Medicare parts A and B. These premiums are *implicitly subsidized*, meaning that the large risk pool that includes active members lowers the premium for the retirees or inactive members.

Premiums charged to those who are eligible for Medicare parts A and B are calculated from their own experience risk pool. This premium is *explicitly subsidized*. Beginning with the 1995-97 budget, the legislature established a portion of the state, school district, and educational service district allocation to be used to provide a subsidy to reduce the health care insurance premiums charged to those retirees eligible for Medicare parts A and B. The amount of the premium reduction is established by the Public Employee's Benefits Board (PEBB), and cannot result in a premium reduction of over 50%. The current retiree premiums can be found in the PEBB pamphlet following this report.

According to the House and Senate Fiscal committee staff, in the 2003-05 biennium the state will pay close to $223 million dollars to subsidize health care insurance for 37,000 Medicare eligible and 10,800 non-Medicare eligible retirees. The estimated cost is evenly split between the implicit and the explicit subsidies.

History

The Health Care Authority (HCA) was established in 1988 (Ch. 107) to replace the State Employees' Insurance Board. In concert, the State Employee Benefits Board was established within the Health Care Authority to design and approve insurance benefit plans for state employees and retirees. The scope of the State Employees' Benefits Board has since been broadened to include employees and retirees of county, municipal, or other political subdivisions hence it has been named the Public Employees' Benefits Board (PEBB).

Recent Legislation

In 2002, the Legislature passed Substitute House Bill (SHB) 2536 (Ch. 142 L of 02) giving school districts that purchase PEBB coverage the ability to participate in the composite rating structure offered to state agencies. The bill required districts joining PEBB on or after September 1, 2002, to pay the entire composite rate charged by the HCA. SHB 2536 also required the school districts to charge their employees the same contributions as state employees.

In 2003, the Legislature passed Substitute Senate Bill (SSB) 5236 (Ch. 158 L of 03), which clarifies the way the HCA collects health care premiums from school districts. This bill affects those districts currently participating in the PEBB program as well as districts requesting participation in the future. The bill requires the HCA to collect the entire premium (composite + employee premium) from the district. However, it allows the employee portion of the PEBB premium to be determined at the district level, as long as the employee pays at least as much as a state employee. SSB 5236 became effective September 1, 2003.

Several bills were introduced in 2003 that did not pass the legislature. HB 1424 sought to create a statutory method for establishing the subsidies for retiree's health care premiums. HB 1425 attempted to open the enrollment in PEBB insurance programs to all TRS, PERS, and SERS retirees and their dependents. This would have allowed retirees who did not take advantage of the initial 60 day enrollment period, to enroll during an annual window. Neither of these bills received a hearing.

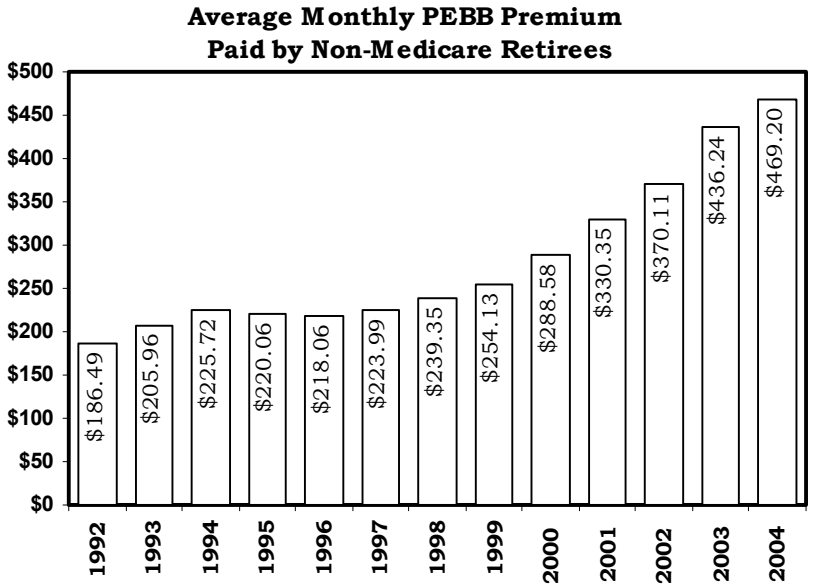
SB 5525 attempted to open the enrollment in PEBB insurance plans for separated (terminated-vested) plan 2 members who were at least age 55 and had 10 years of service. Plan 3 members are afforded this option. Plan 2 members currently must be receiving a retirement allowance to be eligible. This bill did not pass out of committee.

In 2004, HB 3192 attempted to create health savings account options for employees that conformed to section 223, Part VII of subchapter B of chapter 1 of the internal revenue code of 1986. The bill did not receive a hearing.

Retiree Premiums

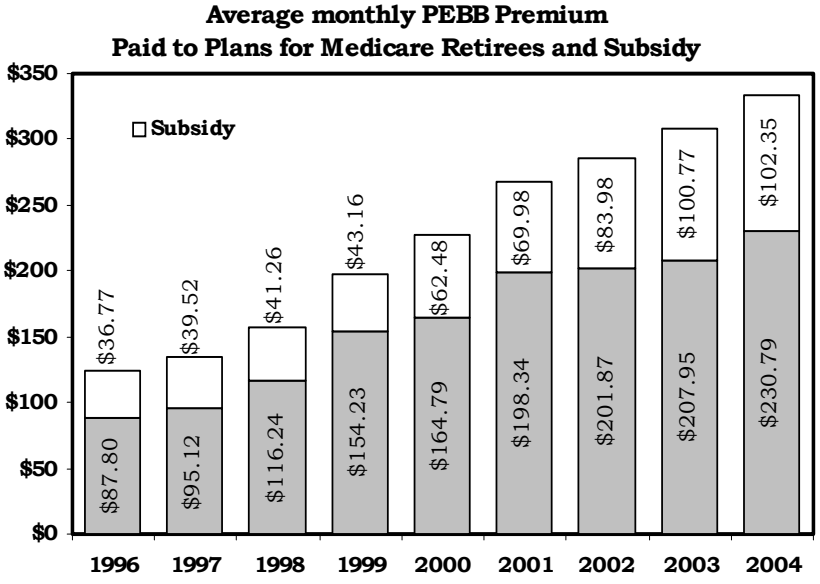
As noted previously, retirees may purchase health insurance by paying the same premiums as are paid by their employers. Over the last ten years, retirees have paid premiums that have changed varying amounts from year to year. Some years they changed a modest amount, and some years, like 2004, they changed a great deal. The weighted average of the PEBB premiums paid by non-Medicare retirees from 1992 to 2004 is illustrated in Figure 1. The average premium increased by over 150% in this period, and most of that increase has occurred in the last 5 years.

Figure 1



The costs borne by Medicare-eligible retirees (age 65 and over) are typically about half that of non-Medicare retirees (see Figure 2). But even with the explicit subsidy, monthly premiums have increased at a 13% annual pace over the past 8 years. The subsidy to support Medicare-eligible PEBB retirees has kept up with these increases.

Figure 2



The most recent premiums for 2004 vary from as little as $125 per month for a single subscriber who is already enrolled in Medicare parts A and B, to over $1,000 per month for a full family not yet eligible for Medicare (see Figure 3 and PEBB pamphlet for premiums by specific plan).

Figure 3

Monthly PEBB Retiree Rates

Effective July 1, 2004

Subscribers not eligible for Medicare or enrolled in Part A only	**Lowest**	**Highest**
Subscriber Only	$322.84	$374.71
Subscriber & Spouse	$641.84	$745.58
Subscriber & Child(ren)	$562.09	$652.86
Full Family	$881.09	$1,023.732
Subscribers enrolled in Parts A & B of Medicare		
Subscriber Only	$125.92	$241.34
Subscriber & Spouse (1 eligible)	$423.41	$612.21
Subscriber & Spouse (2 eligible)	$203.48	$478.84
Subscriber & Child(ren)	$345.36	$519.49
Subscriber & Child(ren) (2 eligible)	$203.48	$478.84
Full Family (1 eligible)	$667.63	$890.36
Full Family (2 eligible)	$445.18	$756.99
Full Family (3 eligible)	$303.30	$716.34
Dental Plans with Medical Plan		
Subscriber Only	$32.38	$39.05
Subscriber & Spouse	$64.76	$78.10
Subscriber & Child(ren)	$64.76	$78.10
Full Family	$97.14	$117.15

Medicare and PEBB

The new Medicare Part D prescription drug benefit in will also have an impact on retiree medical expenses. In 2004, those who are eligible will receive a 10-25% discount on prescription drug costs. In addition, low income enrollees

($12,569 annual income for an individual and $16,862 for a married couple) may receive a $600 per year credit to pay for their prescription drugs. In 2005, Medicare will provide physical exams within 6 months of enrollment in Part B, blood tests for early detection of heart diseases, and diabetes screening. In 2006, all people with Medicare will be able to enroll in plans that cover prescription drugs. Plans will have a $35 monthly premium and a $250 deductible. Thereafter Medicare will cover 75% of all costs up to $2,250 and 95% of all costs above $3,600. Individuals will be responsible for all prescription drug costs between $2,250 and $3,600.

Because of the variety of plans available to retirees enrolled through the PEBB, the Health Care Authority is still analyzing the impact of the Medicare changes in relation to each of those plans. *(See HCA summary of Medicare Prescription Drug, Improvement and Modernization Act of 2003 in Appendix A)*

Policy Analysis

No Pre-funded Medical Coverage

No retirement System/Plan administered by Washington State collects contributions to pre-fund retiree medical benefits. Currently, state, K-12, and higher-ed members who retire before age 65 are allowed to participate in their former employer's risk pool and purchase health insurance at subsidized rates. Even in LEOFF 1, member, employer, and state contributions do not pay for the medical benefits members receive upon retirement. While employers are obligated to provide LEOFF 1 retirees with medical coverage, that coverage is typically provided on a pay-as-you-go basis rather than being pre-funded (there is limited opportunity to pre-fund health insurance liability in a tax qualified trust).

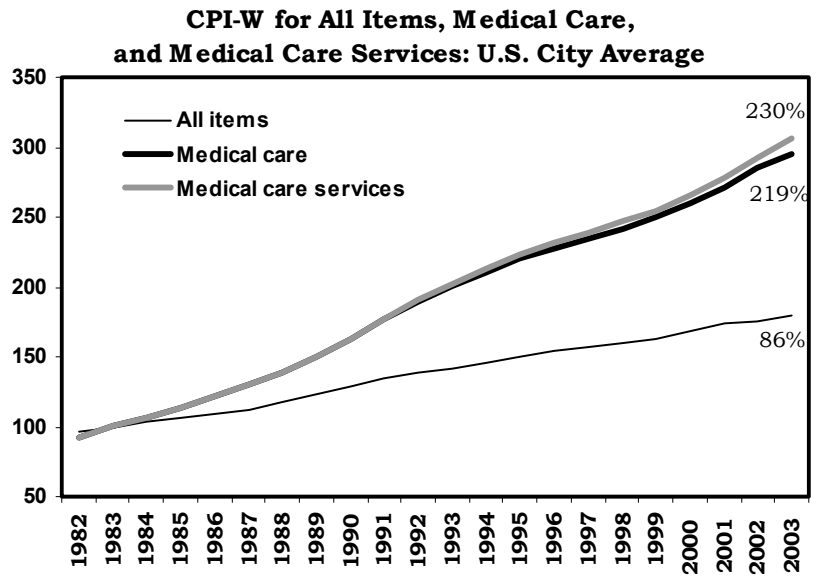
Rising Health Care Expenditures

A significant risk facing retirees today is the rising cost of health care. As health care costs rise beyond the average of all other goods and services, they command a greater share of retirees income, forcing them to scale back on other living expenses and thus diminish the overall adequacy of their retirement benefit.

National Trends

As mentioned above, changes in health care costs have out-paced the change in price of other goods and services. In the period from 1982 to 2003, the overall change in consumer prices nationwide was 86%, or about 3% per year (see Figure 4). In comparison the cost of health care and health care services rose 219% and 230 % respectively, or about 6% per year.

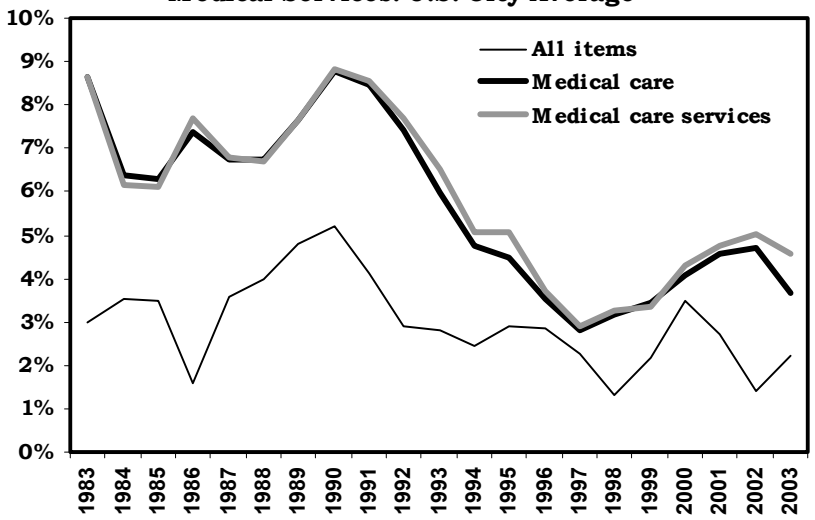
Figure 4



While the cost of medical care may have moderated somewhat during this period, there was no year in which medical costs did not out pace the "all item" average (see Figure 5).

Figure 5

Annual % Changes in All Items, Medical Care, and Medical Services: U.S. City Average



For much of the 1990's, health care costs in this country were held in check. In spite of the tight labor market and strong economy, competitive pressures from domestic as well as international sources, and stringent monetary policies were able to keep annual changes in wages and consumer prices at modest levels. Because of this environment, health care benefits were economically feasible for employers to offer.

Recently this trend began to reverse. In 2001, employers experienced an average health care premium increase of 13%.[1] The National Conference of State Legislatures, citing Deloitte & Touche's September 2003 Employer Survey, reports that the costs of employer-sponsored health care plans rose 14.9% in 2003, from an annual $5,239 per employee in 2002 to $6,020 per employee. Survey respondents predicted that their 2004 plan costs would rise again an average of 14.3% to $6,880 per employee.

Nationally, health care spending in 2004 is projected to be $1.7936 trillion, or 15.5% of the total gross domestic product. This will be $6,167 per capita. However, during the next ten years health spending is expected to outpace economic growth. As a result, the health share of gross domestic product is projected to increase to 18.4% in 2013 according to the Office of the Actuary at the Centers for Medicare and Medicaid Services.

States Health Costs

As of January 1, 2004, 14 states reported a total employer/employee premium for family coverage of more than $900 per month according to the 2004 State Employee Benefits Survey by Workplace Economics Inc., a Washington, DC consulting firm. Fifteen states still pay the full cost of health care coverage for individual employees prior to Medicare eligibility, while just five of those states pay the full premium for family coverage. In most states, the amount paid by the employee and the state depends on the health plan and level of coverage selected by the employee. In four states - Illinois, Kansas, New Mexico, and West Virginia - the portion of the premium paid by the employee varies by salary. Forty-three states now offer pre-tax flexible spending accounts to assist employees with medical, dental, vision, life insurance, and other expenses not covered by health plans.

Washington Public Employee Benefit Costs

In the State of Washington, the price tag to provide health care coverage to state employees increased about 20% in 2003, with both state employees and state government paying more. The Acting Administrator of the Health Care Authority attributed this increase to a variety of factors, including the runaway increases in prescription drug costs, the aging workforce, and demands from doctors and other providers for higher reimbursements, and new technologies.[2]

According to Melissa Ahem, a health care economist and associate professor of health policy and administration at WSU Spokane, some of the driving forces behind rising health care costs are: consumers who want it all, from free choice of physician and loaded benefit packages to unlimited services; increasing numbers of uninsured, with associated costs for care delivered in hospital emergency rooms; increased direct-to-consumer marketing of pharmaceuticals; lack of personal responsibility for health, with more obesity, diabetes, heart disease, etc.; and the huge number of baby boomers moving rapidly toward being Medicare recipients.

Individual Health Expenditures Increase with Age

Individual health care expenses are impossible to predict, but even for healthy retirees, health care can be expensive. The average consumer age 65 and older pays not only a larger share of their income for health care, they also pay a greater absolute amount than someone in their peak earnings years (see Figure 6). According to the Bureau of Labor Statistics, Consumer Expenditure Survey, the average household whose head was age 45 to 54 paid $2,550 in health care expenditures in 2002, or 5.2% of their total household expenses. In comparison, the average household whose head was age 65 or older paid $3,586 in health care expenditures in 2002, or 12.8% of their total household expenses.

Figure 6

Average Consumer Expenditures by Age

Source: BLS, Consumer Expenditure Survey, 2002

	45 - 54		65 and Over	
	Dollars	**Percent**	**Dollars**	**Percent**
Total Expenditures	$48,748	100.0%	$28,105	100.0%
Food & Drink	$6,693	13.7%	$4,147	14.8%
Housing	$15,476	31.7%	$9,176	32.6%
Apparel	$2,029	4.2%	$972	3.5%
Transportation	$9,173	18.8%	$4,481	15.9%
Health Care	**$2,550**	**5.2%**	**$3,586**	**12.8%**
Entertainment	$2,565	5.3%	$1,139	4.1%
Miscellaneous	$3,367	6.9%	$1,638	5.8%
Cash Contributions	$1,571	3.2%	$1,679	6.0%
Insurance & Pensions	$5,323	10.9%	$1,286	4.6%

Moreover, paying for long-term care can wreak havoc on retirement savings. According to the American Health Care Association, the average American man can now expect to spend $56,895 on long-term care while the average American woman will spend close to double that, at $124,370. The price of long-term care is increasing around 7 percent a year. Medicare covers only about 50% of seniors' regular health expenses, excluding nursing home care. The American Association of Retired Persons/People estimates that the national average for the cost of one month in a nursing home is $4,654, or $55,848 annually (costs vary widely depending on geographic location).

Inflation and Retirement

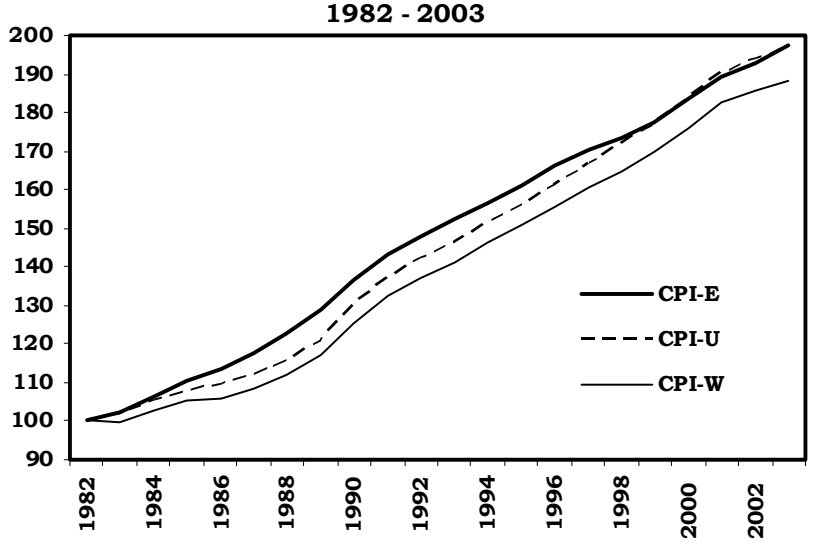
What is apparent from this analysis is that the Age 65 and Over population has distinctly different spending patterns than younger consumers. As a result, the Consumer Price Index for urban wage earners and clerical workers (CPI-W), which measures price changes in the market basket of a younger working population, would not necessarily be representative of the price changes experienced among older consumers. The CPI-W for the Seattle-Tacoma-Bremerton region is used to adjust the monthly allowances of retired members of the plan 2s.

The disparity in consumption patterns of retirees and workers was the concern driving the establishment of an experimental CPI by the U.S. Department of Labor, Bureau of Labor Statistics. Called the CPI-E, this index measures the changes in consumer prices experienced by the population age 62 and older – age 62 being the youngest at which a retiree may receive Social Security.

Comparing the changes in consumer prices as measured by the CPI-U (all urban consumers) and the CPI-W (wage earners and clerical workers) for the Seattle-Tacoma-Bremerton region, with the experimental CPI-E for the nation produces an interesting result. In the mid-to-late 1980s, the CPI-E rose more quickly than either of the two indices for the Seattle region (see Figure 7). By the mid-to-late 1990s, however, the Seattle CPI-U began to converge with the CPI-E and track in unison. As a result, the CPI-U for the Seattle region closely reflected the changes in consumer prices experienced by the Age 62 and Older population nationwide. What is unknown are the consumer price changes experienced by the local Age 62 and older population compared to the populations represented by the local CPIs.

Figure 7

Comparison of Consumer Price Indecies
1982 - 2003



Retiree Health Benefits Comparisons with Other States

Allowing retirees to pay subsidized premiums to continue their health coverage is a common benefit strategy employed by other states as illustrated in Figure 8. Of the systems examined, CalPERS, CalSTRS, Colorado, and Ohio provided for retiree health insurance through the retirement plans. Other comparable states' retirement systems may or may not administer the retiree health insurance, but it's the retirees who pay the bulk of the premiums.

Figure 8

Retiree Health Care Provisions by Select Retirement Plan

System	Pre-Medicare Eligible	Medicare Eligible
Cal PERS	Recent members need 20 yrs. service to receive 100% of state retiree medical contribution.	Member are eligible for supplemental benefits.
Cal STRS	Depends on bargaining agreement -- may be as much as full medical coverage depending on School District.	Members receive regular Medicare coverage
Colorado PERA	Members and dependents are eligible for PERA Care: subsidized medical, dental, and vision plans.	Members enrolled in Medicare part B are also eligible for PERA Care.
Florida (FRS)	Members may continue in employer provided group insurance plan and receive a subsidy of $5 per year of service to a maximum of $150.	Members continue to receive the $5 per year of service subsidy to a maximum of $150 per month
Idaho (PERSI)	Members are allowed to continue coverage in the group medical plan.	Members may purchase supplemental depending on employer.
Iowa (IPERS)	Members are allowed to continue with insurance group.	Members need to have both Parts A and B of Medicare and state becomes secondary payer.
Minnesota (MSRS)	Members are allowed to continue with insurance group (may pay into Health Care Savings Plan when employed.)	Members are eligible for a Medigap policy
Missouri (MOSERS)	Members and family are eligible to participate in any employer provided group insurance plans	Members and family are eligible to participate in any employer provided group insurance plans
Ohio (OPERS)	Majority of health premiums paid by OPERS. Remaining premiums deducted from the recipient's monthly benefit check.	Medicare part B reimbursed. Ohio plans become secondary payers.
Oregon PERS	Members may purchase group health and dental insurance.	Retiree may purchase Medicare companion insurance, state provides $60/month subsidy
Seattle (SCERS)	Members may continue coverage at group rates	Medicare supplemental insurance available

All 50 states make health insurance available to retirees up to the age of 65 and 48 states provide coverage under the state plan for retirees age 65 or older. In 11 states, the state pays the full cost of individual coverage for retirees under age 65, who are not yet eligible for Medicare. Seventeen states pay the full premium for Medicare-eligible retirees over the age of 65. Several states reported that the retiree's share of health care premiums depends upon the date hired, date of retirement or years of service at retirement.[3]

Other Washington Systems/Plans

All retired state, K-12, and Higher-education members of the systems/plans administered by Washington State are eligible to continue their health coverage if they pay the premiums formerly paid by their employer. The only system/plan that offers comprehensive medical coverage for retirees at no cost to the retiree is LEOFF 1, though retirees are still obligated to pay for coverage of their spouse and dependants. Contributions to LEOFF 1 plan, when necessary, required 6% of salary from both the employer and employee with any additional contributions provided by the State – historically double or triple the employer and employee rate. But even at this high level of funding, those contributions did not pay for retiree medical care; that is solely an obligation of the employer, and provided on a pay-as-you-go basis.

Benefits, Compensation and Retirement

Employment benefits have become an increasingly large part of the public employee's compensation package. These benefits include not just retirement plans, but also holiday, vacation, personal, funeral, jury duty, military, family, and sick leave; short-term disability, long-term disability, and life insurance; medical, dental, and vision care; and legally required benefits – unemployment insurance and worker's compensation. As these benefits command a higher share of the compensation package, particularly the "in lieu of wages" benefits like health care insurance, the difference between what is provided during employment and what is provided during retirement grows. As a result, the real replacement value of retirement benefits are lessened.

According to the PEBB rate tables an active PERS member with a spouse and child will receive, in 2004, a tax-free health care benefit from their employer worth upwards of $900 per month -- over $10,000 per year. As a result, the compensation of such a PERS employee could be over $55,000 per year

because of the benefits that supplement that average $45,000 salary. For a 30-year employee, the current benefit structure replaces about 60% of salary, but less than 50% of compensation (see Figure 9). Because of the fixed nature of these benefits, lower wage members' retirement benefits replace less of their compensation, while the replacement rate is more for higher wage members.

Figure 9

Benefit Analysis: Salary and Health Insurance

	Salary for Retirement	Salary + Pre-retirement Health Insurance
Benefit Base	$45,000	$55,000
Retirement Benefit	$27,000	$27,000
Replacement Rate	60%	49%

Retirement benefits relative to total compensation is an issue because of the growing cost of health care and the differing definitions of compensation in Washington State. The statutory language in the PERS, SERS, and TRS retirement chapters limits compensation to essentially wages and salaries. The statutory language governing workers compensation benefits, which includes disability retirement, uses a definition of compensation that includes,"...wages, medical, dental, and vision benefits; room and board, housing, fuel, bonuses, and tips."

Note: Statutory language in the PERS and TRS plans includes the term "average final compensation" but define compensation so as to exclude all other components of the compensation package save wages and salaries. The LEOFF and State Patrol plans use the statutory term "average final salary."

Report Highlights

- State, K-12, and Higher-education retirees are allowed to purchase health insurance through the Public Employee's Benefits Board administered by the Health Care Authority.

- Current premiums range from a low of $125 per month for a single member enrolled in Medicare Parts A and B, to over $1,000 per month for a member with a spouse and child and not yet Medicare eligible.

- The 2004 weighted average premium for retirees not yet Medicare eligible was $469.20

- The 2004 weighted average premium for Medicare-eligible retirees was $333.14, of which $102.35 was subsidized.

- Total health care costs for State, K-12, and Higher Education retirees was an estimated $223 million in the latest biennium.

- Current retirement policies do not provide for pre-funded medical insurance.

- LEOFF 1 retirees receive full medical coverage on a pay-as-you-go basis.

- Consumer prices have risen 86% since 1982 while medical costs have risen upwards of 230%.

- Costs are up because of prescription drugs, aging workforce, higher reimbursements, new technologies, emergency room care for the uninsured, increased obesity, diabetes, and heart disease.

- Those 65 and older spent 12.8% of their annual household expenditures on health care.

- The Seattle CPI-U is more representative of consumer price changes experienced by retirees than the CPI-W.

- A few states pay for retiree medical through their retirement plans, but most subsidize retiree insurance premiums by allowing retirees to join an active member risk pool.

- The definition of “compensation” to calculate allowances in the retirement plans excludes employment benefits while the definition of “compensation” to calculate a disability retirement in the Workers Compensation system does include some employment benefits.

Endnotes

1. *Health Affairs, 2/11/04.*
2. *For a comparison of 2002 vs. 2003 employee contributions for health care costs, see the Health Care Authority's Press Release "State employees will pay more for health insurance," August 6, 2002 at www.hca.wa.gov.*
3. *2004 State Employee Benefits Survey, Workplace Economics.*

Appendix A

Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA): Summary

This document provides summary information on two provisions of the MMA that may be of interest to the Select Committee on Pension Policy.

Part D and the Employer Subsidy

The MMA's highest profile provision was the creation of a drug benefit in Medicare. Currently there is no drug benefit in Medicare Parts A (facility), B (physician), or C (A & B risk/ Medicare Advantage). MMA creates Part D of Medicare, an optional drug benefit that becomes available effective January 1, 2006. Part D will be available through private risk bearing entities: Prescription Drug Plans (PDPs), and Medicare Advantage-Prescription Drug Plans (MA-PD).

Employers that offer retiree health coverage that includes a prescription drug benefit have several options in response to the creation of the Part D benefit:

1. Employers can collect an employer subsidy payment from Medicare for a portion of the drug costs of retirees and their Medicare dependants who do not sign up for Part D. To be eligible for the employer subsidy, the pharmacy benefit provided by the employer must be actuarially equivalent to the Part D benefit. It is not clear whether PEBB retiree coverage will meet that test based on the current retiree subsidy amount paid by the State for retirees.
2. Employers can wrap around the Part D benefit and coordinate with Medicare. The design of the Part D benefit includes a "True Out of Pocket Cost" requirement that makes coordination of benefits less attractive to employers. Amounts paid by employer based insurance do not count toward the beneficiary's True Out of Pocket Cost requirement, so the point at which the Part D catastrophic coverage kicks in is significantly delayed.
3. Employers can sponsor a PDP for their Medicare retirees.

Regulations governing Part D are not final, so analysis of these options is not complete.

Medicare Supplemental- Medigap

Effective 1/1/06, the MMA prohibits the selling, issuance, or renewal of existing Medigap policies with prescription drug coverage to Medicare Part D enrollees. Medigap policy holders may keep their policy with drug coverage and choose to NOT enroll in Part D, but could face a premium penalty should they choose to enroll in Part D at a later date. Also, MMA requests that the National Association of Insurance Commissioners (NAIC) review and revise standards for Medigap policies. The revision is to make the standard policies compliant with MMA and to include two new benefit packages.

NAIC has not formally adopted a new Medigap regulation, but has distributed a draft that is unlikely to see major revisions between now and when it is formally adopted. The draft regulation adds 2 new standard plans, K & L, to the existing plans A through J. In the draft the pharmacy benefit is removed from plans H, I, and J. And, in the draft, plans F and J have a high deductible option. PEBB currently offers plans E & J to its members.

MMA Summary Prepared by HCA
8/18/04